TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Valley Regional Medical Center

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-4040-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As this claim was submitted within 95 days from the date of discharge, we are requesting that the claim be adjusted for payment."

Amount in Dispute: $33,834.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the MAR for the hospital outpatient bill, which is $102.72 for code 73620; $280.61, 76000, and $48.57 for 93005, which totals $431.90. All other codes have a status indicator of "N". And no outlier payment is triggered."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2014	Outpatient Hospital Services	$33,834.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

- 18 – Exact duplicate claim/service
- P12 – Workers compensation jurisdictional fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.480, this bill has been identified as a request for reconsideration or appeal
- 193 – Original payment decision is being maintained
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 920 – Reimbursement is being allowed based upon a dispute.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with several claim adjustment reason codes. The denials for 197 – "Pre-certification" and 16 – "Claim/service lacks information" were not maintained and will not be considered in this review. The submitted medical claim contained three codes, 81003, 73620, and 76000. Per 28 Texas Administrative Code 134.403 (d) "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…"

   As these are the only three billed codes that were reported on the billing of outpatient hospital services, they are all that can be considered in this review.

2. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 81003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 73620 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $57.35. This amount multiplied by 60% yields an unadjusted labor-related amount of $34.41. This amount multiplied by the annual wage index for this facility of 0.8259 yields an adjusted labor-related amount of $28.42. The non-labor related portion is 40% of the APC rate or $22.94. The

sum of the labor and non-labor related amounts is $51.36. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $51.36. This amount multiplied by 200% yields a MAR of $102.72.

- Procedure code 76000 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date. These services are classified under APC 0272, which, per OPPS Addendum A, has a payment rate of $156.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $94.00. This amount multiplied by the annual wage index for this facility of 0.8259 yields an adjusted labor-related amount of $77.63. The non-labor related portion is 40% of the APC rate or $62.67. The sum of the labor and non-labor related amounts is $140.30. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $140.30. This amount multiplied by 200% yields a MAR of $280.60.

4. The total allowable reimbursement for the services in dispute is $383.32. This amount less the amount previously paid by the insurance carrier of $431.90 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September 22, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.